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SIPDIS

DEPT FOR AF/S; AF/EPS; AF/EPS/SDRIANO
DEPT FOR S/OFFICE OF GLOBAL AIDS COORDINATOR
STATE PLEASE PASS TO USAID FOR GLOBAL BUREAU APETERSON
USAID ALSO FOR GH/OHA/CCARRINO AND RROGERS, AFR/SD/DOTT
ALSO FOR AA/EGAT SIMMONS, AA/DCHA WINTER
HHS FOR THE OFFICE OF THE SECRETARY,WSTEIGER AND NIH,HFRANCIS
CDC FOR SBLOUNT AND EMCCRAY

E.O. 12958: N/A
TAGS: ECON KHIV SOCI TBIO EAID SF
SUBJECT: SOUTH AFRICA PUBLIC HEALTH DECEMBER 24 ISSUE

Summary

¶1. Summary. Every two weeks, USEmbassy Pretoria publishes a public health newsletter highlighting South African health issues based on press reports and studies of South African researchers. Comments and analysis do not necessarily reflect the opinion of the U.S. Government. Topics of this week's newsletter cover: Blood Bank Drops Race as a Risk Factor; Genetic Discovery Brings AIDS Vaccines Closer; South African Vaccine Search; Study Focuses on Human Cost of AIDS; AIDS Infections Peaking in KZN; South African Children Victim of Fire; and Court Rules Against Pharmaceutical Pricing Regulations. End Summary.

Blood Bank Drops Race as a Risk Factor

¶2. The South African National Blood Service said that it would revise its controversial profiling system to enable it to risk-rate donors without using race. To ensure patient safety, the current system would remain in place until the new model was developed, said the organization's CEO, Prof Anthon Heyns. The developments follow a politicized row that the organization found itself embroiled in last week, after it emerged that it used race as one factor to risk-rate blood donors for possible HIV infection. It was reported that blood donated by black and coloured donors was routinely discarded; although it later emerged that the organization destroyed only some of the blood products from those donors. The organization used low-risk blood products such as plasma, which can be treated to destroy HIV and discarded high-risk components such as red cells, from which the virus cannot be eradicated. It said race-based risk rating was necessary as there was a higher incidence of HIV among blacks than other races in SA. Although all donated blood is screened for HIV, the tests are unable to detect it in someone who has been recently infected. Following a meeting with officials from the Health Department on Friday, the organization issued a statement saying it had agreed that it was unacceptable to use race as a risk-determinant. It said its risk model was flawed because it was too heavily weighted for race, and would be "appropriately modified to identify the profile of a safe donor without taking race into account". The new risk model would be developed by a committee of experts from the SA Blood Service, the Health Department, the Medical Research Council, the Council for Scientific and Industrial Research, and National Health Laboratory Services. The committee has been given until the end of January to devise the new risk-rating system. Source: Business Day, December 14.

Genetic Discover Brings AIDS Vaccines Closer

¶3. An international study, involving South African scientists published in Nature shows which category of immune cells are actually fighting the HIV virus, which may be the first step towards finding ways of circumventing the virus's ability to avoid vaccines by rapid mutation. Professor Coovadia and Dr. Kiepiela from the University of KwaZulu-Natal worked with the Partners Aids Research Center at Massachusetts General Hospital on the study. The researchers found that the human leukocyte antigen B molecules (HLA-B), which send an alarm to the T cells when a virus or foreign body is present, were important in fighting the HIV virus, while the HLA-A and HLA-C were ineffective. Patients who had particular HLA-B molecules coped better with HIV infection and had a lower viral load. Infected pregnant mothers with a protective version of HLA-B were more likely to survive and less likely to pass the infection to their infant at birth. The three-year research program was conducted in communities hardest hit by the HIV epidemic, most of which are in Africa. Source: The Sunday Independent, Sunday Times, December 12.

South African Vaccine Search

¶4. In South Africa, efforts to find a HIV/AIDS vaccine are led

by the South African AIDS Vaccine Initiative (SAAVI), operating with a budget of $15 million per year, focusing on molecular biology engineering. SAAVI was formed in 1999 by the government and Eskom (an electricity parastatal) in a public-private partnership to coordinate the research, development and testing of a HIV/AIDS vaccine in South Africa. The Departments of Health and Science and Technology along with Eskom, Transnet (a transportation parastatal) and Impala Platinum have contributed its major funding. SAAVI focuses on the development of subtype C HIV/AIDS vaccines, as this subtype accounts for more than 90 percent of infections in Southern Africa. Globally, most HIV vaccines that have been tested to date have been developed for the subtype B virus. There is no conclusive evidence as yet showing that a vaccine based on one subtype of HIV will or will not protect against infection with another HIV subtype. There are two phase-one trials of possible HIV/AIDS vaccines started in South Africa last year. There are another two products that are in the ethics and regulatory approval processes preceding phase one and could possible go into trials soon. Estimates are that there are more than two dozen different designs for a preventive AIDS vaccine currently on trial internationally. The two current South African trial sites, enrolling only volunteers, are at the University of the Witwatersrand HIV/AIDS Vaccine Division of the Perinatal HIV Research Unit at the Chris Hani Baragwanath Hospital in Johannesburg, and the SAAVI Clinical Trial Unit at the Medical Research Council in Durban. Two additional trial locations in Cape Town and Orkney (North West Province) will be added to future sites. Source: Engineering News, December 3-9.

Study Focuses on Human Cost of AIDS

¶5. "The Demographic Impact of HIV/AIDS in South Africa: National Indicators for 2004", compiled by the Medical Research Council's Burden of Disease Research Unit, the Center for Actuarial Research and the Actuarial Society of South Africa, highlights on the human costs of the HIV/AIDS pandemic. The study was based on the latest antenatal clinic results, death register information and data on HIV/AIDS interventions. In 2004, HIV/AIDS related diseases have killed 311,000 people and 5 million out of 46 million South Africans were HIV-positive. By the end of 2004, 600,000 children under 18 will have lost their mothers to AIDS, and by 2015, 2 million children will be maternal orphans. The estimate of 5 million infected people was about a third lower than previous estimates, because condoms, voluntary testing and ARV treatment are starting to impact infections. The incidence of HIV infections passed its peak in all age and gender groups between 1997 and 2001, except for males in the 15-24 age group, which is projected to peak around 90,000 new infections in 2006. According to the 2004 ASSA model, the national average life expectancy is just under 50 years old. The model also suggests that in 2005, around 500,000 people need ARV treatment. Currently 19,500 HIV-positive people are on public sector provided treatment and 45,000 are on private sector dispensed treatment. Women from the ages of 15-49 account for 2.55 million of all HIV infections to date, while HIV prevalence peaks between the ages of 25-29 for females and 30-34 for males. The HIV virus is responsible for a declining annual population growth rate, from a high of 2.7 percent in 1994-96 to 0.8 percent in 2004; and a projected 0.3 percent by 2015. The most economically active segment of the population, aged 35 to 49 will not grow by 2015. By 2015, 743,000 South Africans will need ARV treatment. Source: The Star, December 4.

AIDS Infections Peaking in KZN

¶6. The rate of new HIV and Aids infections appears to have peaked in KwaZulu-Natal, according to Professor Alan Whiteside, the head of the Health, Economics and HIV and Aids Division at the University of KwaZulu-Natal. The latest research showed an increase in the number of orphans, and a greater burden on provincial health care. Whiteside's department had been conducting a four-year study into the effects of HIV and Aids on orphans in the Newcastle area. He said that while the incidence of orphans in the area was growing, research had shown that the community was coping with the problem. He commended the quality of the care given to HIV/AIDS patients in KZN provincial hospitals. Whiteside said the South African authorities would have to formulate a "new agenda" to deal with the effects of HIV/Aids by the time of the next election in ¶2009. By then, the government would have a better idea of the impact of HIV/Aids. Source: The Mercury, December 13.

South African Children Victim of Fire

¶7. An estimated 1,100 children younger than five are burnt to death each year, most dying in their own homes. A Medical Research Council study found fires account for about two percent of deaths in children aged one and four. In the five to nine age group, fire accounts for four percent of all deaths. The Fire Protection Association of SA reports that

more than 10 percent of fire emergency calls involve homes. Open flames, electrical faults and cooking are the most common causes, says the association. Burns specialist Dr Ian Thompson says most child-burn patients are injured at home due to not being supervised. Often, in the case of informal dwellings, a sleeping child is burnt when the structure catches fire. Sepsis, or the infection of burn wounds, causes up to 85 percent of deaths. Serious burn injuries not only result in physical trauma but in severe psychological trauma. Source: Cape Argus, December 11.

Court Rules Against Pharmaceutical Pricing Regulations

¶8. The Supreme Court of Appeal ruled against the Department of Health's pharmaceutical pricing regulations by stating that the dispensing fees proposed by the regulations were not appropriate because they did not consider the viability of the dispensing industry and that the regulations relating to the single exit price introduced a price control mechanism, which the Act had not intended. The Department of Health raised jurisdictional issues since the Cape High Court denied the industry a chance of appeal. The Court of Appeal dismissed these issues of jurisdiction by ruling that the Cape High Court's delay in granting leave to appeal was so unreasonable as to breach the constitutional right to a fair hearing. The regulations provided for a pricing system that defined a single exit price of manufacturers and a dispensing fee, which, for pharmacists, amounted to R16 without a medical prescription and R26 with a prescription. The court did not challenge government's right to administer prices but stated that the lack of any document describing how dispensing fees were calculated meant that the government did not consider the long-term viability of the retail drug sector. The Health Department was ordered to pay the court costs. Source: Independent Foreign Service, December 20.

¶9. Comment. The Health Department has signaled that it would file an appeal against this court judgment in the Constitutional Court (equivalent to the U.S. Supreme Court), stating that international experts regarded the pricing regulations as reasonable and beneficial to consumers. According to the department, the single exit price set by drug manufacturers since June 2004 reduced the price of medicines by 19 percent. Drug retailers have long argued that the dispensing fee set by the government was so low that many retailers would be forced to close. Until the Constitutional Court rules, the existing price regulations have been rescinded and pharmacists are again entitled to charge varied dispensing fees, while manufacturers can charge different prices to different buyers. End comment.

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